Division of Workers' Compensation

PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
David Juan Zehr

Respondent Name
Liberty Insurance Corp

MFDR Tracking Number
M4-23-2199-01

Carrier's Austin Representative
Box Number 1

DWC Date Received
May 5, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 22, 2022	29125	$155.40	$0.00
	Total	$155.40	$0.00

Requestor's Position

The requestor did not submit a position statement with their request for medical fee dispute. They did submit a copy of their reconsideration that states, "I have circled on the patient medical record that shows us giving patient widget."

Amount in Dispute: $155.40

Respondent's Position

"Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bills in question for manual review to determine if additional monies are owed. We will provide a supplemental response once the bill auditing company has finalized their review."

Response Submitted by: Gallagher Bassett

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC 134.203 sets out the billing and coding guidelines for professional services.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- 90563, 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- B12 – Services not documented in patient medical records.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. Is the insurance carrier's denial supported?
2. Is requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of code 29125 with a description of "Application of short arm splint (forearm to hand), static. The physician applies a splint from the forearm to hand. A short arm splint is used to immobilize the wrist. Cotton padding is applied from midforearm to the midpalm region. Plaster strips or fiberglass splint material are applied along the palm side of the hand, extending to midforearm, maintain the wrist in the desired position. An Ace wrap is applied by the physician to hold the splint material in position."

   Review of the submitted medical record found, "We will ask permission for the injection and give him a widget today to try on it."

   A "Widget Brace" is a prefabricated brace. The application of a short arm splint as described above was not found within submitted medical record. The insurance carrier's denial is supported.

2. No payment is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requestor has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		July 13, 2023
Signature	Medical Fee Dispute Resolution Officer	Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option three or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1 (d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción tres o correo electronico CompConnection@tdi.texas.gov.